U.S. Department of Labor

Office of Administrative Law Judges
Heritage Plaza Bldg. - Suite 530
111 Veterans Memorial Blvd
Metairie, LA 70005

(504) 589-6201
(504) 589-6268 (FAX)

Issue Date: 19 December 2002

CASE NUMBER: 2002-LHC-1047

OWCP NO.: 07-159445

IN THE MATTER OF

GEORGE MILLER,
Claimant

v.

AVONDALE INDUSTRIES, INC.,
Employer

APPEARANCES:

Philip T. Hager, Esq,
On behalf of Claimant

Richard S. Vale, Esq.
On behalf of Employer

Before: Clement J. Kennington
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, *et. seq.*, brought by George Miller (Claimant) against Avondale Industries, Inc.(Employer). The issues raised by the parties could not be resolved administratively, and the matter was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held before me on October 2, 2002 in Metairie, Louisiana.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their respective positions. Claimant testified and called his wife (Sharon Miller) as a witness. Claimant introduced 28 exhibits of which I admitted all but the vocational report of Thomas J. Munier, which was not timely submitted and concerning which Employer objected since it had no opportunity to cross examine

Munier. Claimant's 27 admitted exhibits included various DOL forms (LS 18, 200, 202, 203,206, 207, 208, 280); Employer payroll and first aid records of Claimant; Winn Dixie and Brister's Design and Manufacturing payroll records of Claimant; medical records of Drs. Louis J. Provenza, Ted J. Hudspeth, E. Thomas Cullom, III, and John Jackson; records of Affiliated Therapy Services and depositions of Drs. Hudspeth, Applebaum, and Cullom, and Christine Coker and Steve Scianna; a letter from Claimant's counsel to adjuster, F.A. Richard & Associates; a report of Thomas J. Munier and a lumbar myelogram of Claimant taken on November 6, 2002. [1]

Employer called two witnesses (Susan Landry and Kevin Lalonde) and introduced 17 exhibits which were admitted including various DOL forms (LS 18, 202, 206, 207, 208); Claimant's personnel and payroll records; medical records from Drs. Hudspeth, Cullom, Jackson, Applebaum, Provenza, therapy and first aid records; return to work letter dated September 18, 2001; and depositions of Drs. Applebaum, Cullom, [2] Post-hearing briefs were filed by the parties. Based upon the stipulations of the parties, the evidence introduced, my observation of the witness demeanor and the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. Claimant was injured on February 23, 2001.

2. The injury occurred in the course and scope of his employment with Employer while Claimant was an employee of Employer.

3. Employer was advised of the injury on February 23, 2001.

4. Employer filed Notices of Controversion on September 10, 2001 and October 24, 2001.

5. An informal conference was held on December 11, 2001.

6. Claimant's average weekly wage at the time of injury was $635.83.

---

[1] References to the transcript and exhibits are as follows: trial transcript- Tr.__; Claimant's exhibits- CX-__, p.__; Employer exhibits- EX-__, p.__; Administrative Law Judge exhibits- ALJX-__; p.___.

[2] The record contains many duplicate exhibits such as CX-1 and EX-1, CX-4 and EX-3, p.1; CX-3 and EX-4; CX-12 and EX-12; CX-15 and EX-11; CX-16 and EX-6; CX-17 and EX-7; CX-19 and EX-8; CX-23 and EX-16; CX-26 and EX-15; CX-21 and EX-14. Where the record contains duplicate exhibits reference will generally be made to only one exhibit.

7. Employer paid weekly disability benefits of $423.90 from February 26, 2001 to September 9, 2001 totaling $11,969.20.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Nature and extent of injury.

2. Choice of physicians.

3. Whether or not Employer offered Claimant regular, continuous employment post-injury.

4. Whether or not Employer established suitable alternative employment for Claimant.

5. Whether or not Claimant will be required to work with excruciating pain.

III. STATEMENT OF THE CASE

A. Chronology:

Claimant is a 36 year old male born on December 13, 1966. Claimant has a 12th grade education and is a certified welder with 3 months of vocational technical school training in that field. (CX-27, Tr. 45, 96). Prior to his employment with Employer Claimant worked as a car mechanic, construction worker, fast food cook and greenhouse plant care laborer. (EX-12, p. 7).

Employer hired Claimant as a tacker or fitter on June 27, 1988. (EX-12, p. 1). Claimant worked in that capacity and as a welder and welder foreman for Employer at various yard locations performing heavy work wherein he did repeated kneeling, squatting as he climbed in and out of ship hulls. Claimant worked for Employer until his most recent injury on February 23, 2001. (Tr.45-48). Prior to this time Claimant experienced a series of minor back injuries for which he was treated at Employer's onsite health clinic. Employer first aid records show Claimant receiving conservative treatment for back injures occurring on the following dates: November 26, 1990 (low back pull while lifting. 80 pound chocks) (EX-12, pp. 79); March 21, 1991 (back injury in main yard, *Id.* at 74); July 30, 1992 (lower back pull while installing door inserts, *Id.* at 70); September 6, 1994 (lumbar strain due to slip and fall, *Id.* at 53-66); September 30, 1994 (low back pain while picking up 12 foot long angle iron, *Id.* at 60); March, 1998 (low back pain from slip and fall , *Id.* at 45,46); February 18, 1999 (lumbar strain while pulling welding leads, *Id.* at 27-43).

Before the September 6, 1994 injury, treatment records were sketchy and difficult to read. Concerning the September 6, 1994 slip and fall accident, Dr. Joseph Mabey of the West Jefferson Medical Center provided more detailed information showing Claimant complaining about a constant level 3 out of 10 pulling and piercing right lower back pain with intermitted level 8 out of 10 back pain with movement. Dr. Mabey examined Claimant on September 22, 1994 and found decreased spinal curves limited range of motion, spasm and tenderness with palpation, decreased abdominal and erector spinae musculature, tight hamstring and adverse neural tension demonstrated by straight leg raising. Dr Mabey prescribed therapy 3 times a week for 2 weeks. *Id.* at 64, 65. Claimant apparently missed some work because of this accident but returned at least by September 30, 1994 only to re-injure his back while lifting angle iron for which Claimant received additional therapy through October 6, 1994. *Id.* at 57, 58, 59.

From October, 1994 until March 1998, Claimant suffered no additional back injuries and was able to work without significant pain. However, about March 14, 1998, Claimant began to experience severe low back pain preventing him from work. Claimant went to his family physician, Dr. Hudspeth, who ordered a CT lumbar scan and restricted Claimant to light duty. *Id.* at 40. On March 24, 1998, neurosurgeon, Dr. Provenza, examined Claimant and reviewed the CT scan which he interpreted as showing a diffuse annular bulge with mild central and left paracentral disc protrusion at L4/5 for which he prescribed Motrin and Soma, therapy 2 times a week and a follow up visit in 6 weeks. (CX-15, pp. 3, 4; EX-12, pp. 45, 46).

The record does not indicate how long Claimant was off work or in a light duty status following the recurrence of back pain. However, on February 18, 1999, Claimant had returned to work and was welding in the main yard when he again felt a sharp pain in his lower back as he pulled welding leads. *Id.* at 39. Claimant was evaluated at West Jefferson Medical Center, prescribed physical therapy and placed on limited duty until March 18, 1999. *Id.* at 37, 38. During the therapy sessions, Claimant reported a 4 out of 10 level pain which increased with prolonged sitting and demonstrated limited range of motion. *Id.* at 34.

Claimant had no further back injuries until February 23, 2001, on which date Claimant while marking welds on the Polar C hull slipped and fell off a beam landing between two beams several feet below. Claimant was initially treated by Employer paramedic, Susan Landry and transferred by ambulance to Employer's clinic where he was examined by an Employer physician and released to return to work on February 26, 2001. Claimant returned to work on February 26, 2001 and was examined by Employer's physician, Dr. Corcoran. The exam showed no improvements and Claimant did not return to work. Thereafter, Dr. Corcoran re-examined Claimant on March 1, and 5, 2001, but found no improvement even with use of medication and recommended further examination by Dr. Hudspeth and an orthopedic physician for possible lumbar disc disease. *Id.* at 12-14.

Dr. Hudspeth saw Claimant on March 6, 2001. Claimant described the injury wherein he fell on his back after slipping as he was marking welds inside a unit. Claimant complained of low back greater on the right than left side. The exam found spasm and tenderness of both latissimus dorsi and the right SI for which Dr. Hudspeth prescribed Skelaxin. (CX-15, p. 1). On March 20, 2001, Dr. Hudspeth re-examined Claimant, found no change in his condition**,** and prescribed Darvocet, Celebrex

and Skelaxin. *Id.* at 3. Dr. Hudspeth recommended therapy of 3 visits for two weeks and found Claimant unable to work. *Id.* at 5. On April 3, 2001, Dr. Hudspeth re-examined Claimant, found no change in his condition, prescribed continued use of medications and therapy while finding him again unable to work. *Id*. at 8. On April 23, 2000, Dr. Hudspeth re-examined Claimant and found additional pain complaints associated with defecation whereupon pain radiated into both legs. *Id.* at 10. Dr. Hudspeth scheduled a lumbar spine MRI for the following day.

On April 24, 2001, Claimant underwent a lumbar MRI which showed the following abnormal results: L2-3: mild loss of height and signal intensity of the L2-3 disc with a slight broad based extradural defect extending from the superior margin of L3 to the middle third of L2 resulting in mild anterior indentation of the thecal sac giving an appearance of extruded disc material; L4-5: moderate loss of height and signal intensity with moderate annular bulding and mild anterior indentation of the thecal sac with facet arthropath and ligamentum flavum hypertrophy; L5-S1: moderate loss of height and signal intensity with moderate annular bulging demonstrating a small focal protrustion and minimal indention of the thecal sac. *Id.* at 11,12. Following this MRI Dr. Hudspeth found Claimant unable to work for an additional month due to lower back pain and herniated disc. *Id.* at 13, 14.

Dr. Hudspeth turned over Claimant's treatment to Dr. Cullom upon a referral from claims adjuster, Ryan Downs. Dr. Cullom saw Claimant on April 30, 2001. Dr. Cullom took a history of the accident and subsequent treatment and noted Claimant complaining of low back pain radiating in the right leg with thigh weakness and difficulty standing and sitting. An examination followed showing tendeness in the right SI joint and minimal tenderness in the spine but no spasm. Range of motion was limited to 45 degrees on flexion with extension increasing SI joint pain. Straight leg raises cause back pain greater on right side than left but no postive findings. *Id.* at 1-4. Dr. Cullom reviewed the April 24 MRI and noted straightening of lumbar spine, degenerative changes at L4-5 and L5-S1 with protrusions at both levels and a slight bulge at L4-5 with facet atrophy and a central protrusion at L5-S1. *Id.* at 5.

Claimant returned to Dr. Cullom on June 7, and July 26, 2001. Previous to the June 7th visit, Claimant had received an SI joint injection which relieved pain only for 48 hours**.** On exam, Claimant demonstrated tenderness at the SI joint. Patrick's test was mildly positive on the right with a mild analgic gait favoring the right leg. Dr. Cullom prescribed additional therapy and use of Celebrex. (EX-7, p. 5). On the last visit of July 26, 2001, Dr. Cullom noted that Claimant had not completed therapy sessions due to continued back and right leg pain and had cease home exercises. On exam Claimant exhibited tenderness in the back and right SI joint. Otherwise the exam was normal. Dr.Collum stated he had nothing further to offer other than scheduling a functional capacity evaluation. *Id.* at 6.

On September 17, 2001, Dr. Cullom filed out a medical questionare on Claimant for Adjuster Ryan Downs based upon an FCE which Claimant underwent on August 13, 2001. On the medical questionaire Dr. Cullom indicated that as of September 17, 2001, Claimant could return to at least light duty having reached maximum medical improvement of August 13, 2001 and that he, Dr. Cullom, imposed no restrictions on Claimant's activities. *Id.* at 9.

Concerning the FCE, occupational therapist, Kevin Lalonde, scheduled an FCE for Claimant on August 13 and 14, 2001. Claimant completed only the first day of testing stating that he was in pain and did not want to increase pain levels by undergoing a second day of testing. Lalonde found no "objective" basis to support Claimant's pain complaints and found Claimant able to work perform work at the heavy level. (EX-9).

On September 18, 2001, Downs by letter advised Claimant that Dr. Collum had released him to return to work without restriction, and that upon receipt of this letter should report to Employer for reinstatement. (EX-13). On September 26, 2001, Claimant reported to Employer's clinic to be cleared for work but informed Landry that he could not perform his job due to right hip and leg pain whereupon Landry gave him a "job pass out" telling him to have his doctor re-evaluate him and fill out a long form, medical questionnaire. (EX-12, p.14). On October 9, 2001, Dr. Hudspeth returned the form indicating a diagnosis of low back pain and herniated disc, use of anti infammatories, referral for neurosurgery evaluations to Collum after May 11, 2001 and to Dr. Jackson on October 3, 2001. *Id.* at 18.

Dr. Jackson evaluated Claimant onOctober 22, 2001. Claimant related the accident, symptoms and subsequent medical treatment. Dr. Jackson examined Claimant and found no neurological deficits and noted after studying the April 24, 2001 MRI that Claimant had disc pathology with a mild bulge at L2-3 slightly indenting the dura, an L4-5 bulge also slightly indenting the dura, and a midline bulge at L4-5 which did not indent the dura. In essence, Dr. Jackson classified Claimant's symptoms as a disabling pain problem for which he recommended continued conservative treatment with anti-inflammatory drugs, muscle relaxers, and analgesics, back massage, ultrasound and diathermy, but not physical therapy. (CX-19).[3]

On September 13, 2002, at Employer's request, Claimant underwent a third neurological evaluation by Dr. Applebaum who issued a report that same day. During that evaluation Claimant related the accident, symptoms, and subsequent treatment and evaluations. Dr. Applebaum noted that Claimant sustained a lumbar sprain in 1994 but was symptom free several weeks later. The examination revealed minimal limitation of lumbar motion. Straight leg raising was positive at 10 degrees on the right with pain referred to the buttock and a positive Lasegue's sign. Straight leg raising was positive on the left a 40 degrees with back pain and a positive Lasegue's sign. Bowstring sign was positive bilaterally with the Patrick's sign weakly positive bilaterally especially with internal hip rotation. Claimant was tender over the right sacroiliac joint.

Dr. Applebaum found moderate mechanical but no neurological deficits. He was uncertain about the etiology of Claimant's symptoms stating that Claimant may well have sacroiliac joint problems. Dr. Applebaum recommended a lumbar myleogram and CAT scan to rule out significant spinal problems, use of Celebrex, and possibly a bone scan.

---

[3] Claimant underwent therapy for low back pain and SI joint dysfunction at Affliliated Therapy Services, Inc., beginning in March, 2001.

On October 7, 2002, Dr. Applebaum issued a second report after reviewing additional records including Dr. Cullom's deposition, MRI and CT films. Dr. Applebaum read the MRI as showing loss of water content at L4-5 and L5-S1 with slight narrowing of disc space and slight bulding and no nerve root compression indicating degenerative disc disease of the lumbar spine. Dr. Applebaum found a slight bulge at L2-3 that was clinically insignificant with no significant sacroiliac joint abnormality and concluded by reaffirming his previous recommendations. (CX-10).

On November 6, 2002, Claimant underwent a lumbar myelogram and post myleogram CT which resulted in the following impression:

> 1. Multifactorial central spinal stenosis at L4-5 secondary to broad based disc protrusion or extrusion with mild foraminal narrowing bilaterally.
>
> 2. Small midline disc protrusion at L5-S1 without evidence of significant central, lateral or foraminal stenosis.
>
> 3. Annular bulge at L2-3 without evidence of significant central, lateral or foraminal stenosis.
>
> 4. Asymmetry of the left side of the dural sac secondary to isoattenuation structure in the left lateral recess of L4 just above the L4-5 disc space.
>
> Concerning the central spinal stenosis the report stated:
>
> Degenerative type changes are seen at L4-5disc space. There is significant central spinal stenosis at L4-5 secondary to Isointense material which is consistent with either extruded type or protruded type disc herniation. Disc material appears to exten slightly below the level of the disc space and raises the possibility of Type II disc extrusion. Bilateral foraminal narrowing secondary to facet joint arthropathy and the disc abnormality is demonstrated.

Claimant never returned to work for Employer. However, he did seek and find full-time employment with Winn Dixie as a maintenance mechanic in Winn Dixie's Warehouse where he worked from November 20, 2001 through June 28, 2002, when he was forced to resign because of a failure to disclose back injury on job application. (EX-10). Claimant started at $12.00 per hour and received on wage increase to $12.20 per hour on May 29, 2002. Thereafter, he has worked as a welder for Bristers Design & Manufacturing of Roseland, Louisiana from October 19, 2002 to the present making $9.50 per hour, 40 hours per week. (CX-28). Claimant worked 40 hours per week at a rate of $12.00 per hour.

B. Testimony of Claimant and his wife, Sharon Miller:

Claimant's testimony dealt with his work background and related injuries, symptoms and treatment. Claimant testified that he had a high school education plus vocational training that enable

him to become a certified welder. Prior to being employed by Employer, Claimant had worked as a burner for Kaiser Aluminum and Dow Chemical and had never experienced any back problems. On June 27, 1988 Claimant began work as a fitter for Employer cutting metal and performing various maintenance duties throughout Employer's yard at $12.50 per hour. Later, Employer assigned Claimant to weld which required heavy pushing and pulling along with considerable kneeling, and squatting as he climbed in and out of ship hulls. (Tr. 48, 49, 96-98).

Claimant testified that he had two significant accidents prior to the current injury of February 23, 2001. The first accident occurred on September 6, 1994 while he was working on a dry dock and fell about 6 feet hurting his lower back. Although he received medication and physical therapy for this injury, Claimant asserted that he continued to experience a level 2 to 3 out of 10 pain following this accident which would increase to a level 5or 6 and on occasion to a level 8 with activity. Claimant complained about the pain only when it reached a level 8 at which time he received first aid treatment. On September 30 and October 3, 1994. (Tr. 51-63).

In March, 1998, Claimant saw Dr. Provenza for back pain. (CX-12, p. 45). Dr. Provenza examined Claimant and ordered a CAT scan showing a herniated disc. Dr. Provenza provided conservative care with good results allowing Claimant to return to work without restrictions. (Tr. 63-65, 98, 99). Claimant worked without incident following this injury until February 18, 1999, when he felt a sharp back pain as he was pulling welding leads. Claimant sought first aid treatment and then received physical therapy at West Jefferson Medical Center. Despite this treatment Claimant's constant level of pain went for a level 3 to a level 4. (Tr. 66-68).

Claimant testified that despite the pain he continued to work because of economic necessity and did so until a third back injury on February 23, 2001 when he slipped on wet scaffolding and landed between two beams. Claimant received first aid and subsequent medical treatment from family physician Dr. Hudspeth, and later on what he thought was a referral from Dr. Hudspeth, treatment from Dr. Cullom. The third injury caused the pain level to increase from a constant 4 to 5 up to a level 8 or 9 with heavy lifting or prolonged sitting as was evidence following the first day of the FCE which was arranged for by Cullom.

Claimant described the FCE and his complaints of pain to the therapist which apparently went unheeded. As a result of the strenuous activities of the first day of FCE testing which produced unbearable (level 8 -9) pain Claimant was unable to complete the second day of testing. (Tr. 72-79).

Upon learning that Employer was directing him to report back to work based upon an unconditional release by Dr. Cullom. Claimant tried to see Dr. Cullom for an explanation about the medical release since he continued to experience severe pain. Dr. Cullom refused to see him whereupon Claimant reported back to work telling first aide personnel, Ms. Landry, about his inability to work due to pain. In turn, Ms. Landry gave him an additional medical form to be filled out by his treating physician which he did and later returned to Employer representative Joey Anderson. Thereafter, Employer never contacted Claimant again or offered any light duty work. (Tr. 80-87, 106-112, 119).

On November 20, 2001, Claimant found work with Winn Dixie as a maintenance person repairing hoses and monitoring and repairing machines that made plastic bottles for milk and orange juice. On September 18, 2002, Claimant resigned that position when informed that unless he did so he would be terminated for falsifying him job application by not indicating prior back injuries. (Tr. 99-104). Claimant worked 40 hour per week at this job and was required to drive only 8 miles to work as opposed to Employer located 1 ½ hours from Claimant's home. (Tr. 113). The job at Winn Dixie involved no heavy lifting, paid $12 per hour which increased to $12.50 per hour as opposed to Employer where as welding foreman he made $16.75 per hour. Also contrary to the welding job with Employer, Winn Dixie allowed Claimant to take breaks as needed. (Tr. 88-94).

In essence, Claimant testified that he could not perform his past work for Employer due to low back (buttocks) and right leg pain associated with weak back muscles and leg numbness. (Tr. 95-96). Claimant testified that he told Ms. Landry about his inability to work because he knew that his job which required pulling heavy lines would result in the same type of intense and unbearable pain he had experienced as a result of the FCE. (Tr. 124-128).

Sharon Miller testified that her husband never fully recovered from the September, 1994, injury, which resulted in missed work and therapy for several weeks. (Tr. 131). For example, Claimant had difficulty in getting out of bed in the morning and doing household repairs and yard work during which he would have to come inside and sit down and take medication due to back pain. (Tr. 132). Following the February, 2001 injury, Claimant sought help from Dr. Hudspeth for increase pain which he experienced when sitting for prolonged periods of time. Yard work became increasingly more difficult resulting in more discomfort at night and failure to complete the task at hand. (Tr. 133, 134).

Following the August, 2001, FCE, Claimant was barely able to walk and had to lie down when he came home. The following day Sharon Miller called the therapist who had administered the FCE, Kevin Lalonde and said her husband was unable to complete the second day of testing. Lalonde responded that Claimant had to finish the test whereupon Claimant reported as directed but was unable to finish the testing. (Tr. 135, 136).

Shortly thereafter, Carrier reduced Claimant's compensation prompting Sharon Miller to call Downs and learned that Dr. Cullom had released Claimant to return to work without restrictions. Claimant tried to contact Dr. Cullom but was unsuccessful. Sharon Miller then contacted Downs who told her that Claimant needed to report for work. She then contacted Downs' supervisor, Joey Anderson and explained that although Dr. Collum had released Claimant to return to work, Claimant was unable to because of pain. Anderson told her that Claimant should return to the doctor whereupon Claimant went back to Dr. Hudspeth and then Dr. Jackson. (Tr. 137-140).

Sharon Miller further testified that when Claimant attempted to return to work he was still having back pain and had difficulty sitting and walking. Claimant then sought out other employment with Winn Dixie which he held until forced to resign because of a failure to indicate prior back problems on his job application. After losing that job Claimant applied for other work. (Tr. 141-143).

C. Testimony of Employer Witnesses Steve Scianna and Christine Coker

Steve Scianna, Employer's safety manager, gave an overview of Employer's return to work policy for injured employees. Scianna testified that once an employee was released to return to work by their physician without restriction, Employer simply reinstated the employee to their former job. (CX-24, p. 6). If the employee complained of having too much pain that would cause himself to be a danger to not only himself but other workers, Scianna would still rely upon the physician opinion and reinstate the employee. *Id.* at 7, 8. Scianna further testified, that Employer did not create jobs to fit an injured workers limitations but when an injured worker returned would determine whether they had an existing job which the injured worker could perform with their limitations and then place them in such work. *Id.* at 9,10. In such a situation the Employer's worker's compensation administrator would present the case to Employer's Return to Work Committee comprised of medical, manufacturing, and human resources personnel, who in turn, would determine whether Employer had a job that would accomodate the injured worker's restrictions. *Id.* at 10-13.

Christine Coker, Employer's medical records coordinator, testified that she was responsible for keeping all records on employee injuries. Coker identified the February 23, 2001 injury report showing Claimant's slip and fall resulting in a low back injury followed by treatment on Employer's premises from paramedic Susan Landry and then conservative treatment at Employer's clinic from Drs. Corcoran and Mabey on February 23, 26, and 28, 2001with minimal success.

Coker testified that Employer received a return to work notice from Dr. Cullom dated September 17, 2001, indicating that Claimant had reached maximum medical improvement on August 13 and that he had no work related restrictions. (CX-22, p. 40). According to Claimant's medical records, Dr. Cullom last saw Claimant on July 26, 2001 at which time he was continuing to complain of back and hip pain while exhibiting tenderness in the back and right SI or SL joint. *Id.* at 42,43. Coker then identified Employer's "Request for Medical Information" which Dr. Hudspeth filled out on Claimant on October 9, 2001, indicating low back pain and herniated disc with an unknown prognosis and a referral to Dr. Jackson for evaluation on October 3, 2001. *Id.* at 51, 52.

D. Testimony of Employer Witnesses Susan Landry and Kevin Lalonde:

Susan Landry, who is employed as a paramedic for Employer and helps to run Employer clinic, testified that when Claimant was hurt in February, 2001 she responded by having Claimant removed from the job site via ambulance. As a paramedic she administered first aid to Claimant and filled out appropriate paper work on the injury, including giving Claimant a personal pass for medical reasons.

When Claimant returned to work on September 26, 2001, he reported to Ms. Landry for clearance and to received appropriate job assignment. Claimant told Ms. Landry that although he had been cleared to return to work, the pain prevented him from performing his regular duties whereupon

Ms. Landry gave him a "job pass out" and a long form medical report to be filled out by his doctor. Ms. Landry testified that she was prepared to sign a release sending Claimant back to his prior foreman. However, when informed about an inability to do his former work, she sent him back for further medical evaluation. (Tr. 11-26).

On cross, Ms. Landry admitted that when Claimant returned to work on September 26, 2001, he explained that he was unable to work because of right hip and leg pain. (Tr. 37). Ms. Landry further admitted that she never received any subsequent evaluation from Dr. Jackson, but that she relied upon a doctor's evaluation when returning a injured worker to work and that she never received any specific work restrictions on Claimant from any doctor. (Tr. 43). However, she admitted receiving a long form from Dr. Hudspeth indicating a diagnosis of low back pain and a herniated disc. (Tr. 37, 38).

Kevin Lalonde, who is employed by Affiliated Therapy Services as an occupational therapist, testified that he administered an FCE to Claimant on August 13, 2001 at Dr. Cullom's request. In the past, Dr. Cullom had requested frequent FCEs from Lalonde. (Tr. 154, 155). Lalonde explained the FCE which was based on standardized testing utilizing the Eisenhagen Work Systems and a heart monitor. (Tr 162-166). Lalonde testified that Claimant voiced no complaints during the first day of testing lifting 80 pound from floor to waist. (Tr. 173, 174). However, on the second day, Claimant called and said he was on his knees and not able to do anything. Claimant reported however for the FCE, but was able to do only heel walking and toe raises because of pain and a desire to avoid greater pain when subjected to further testing. (Tr. 178-181). Lalonde found no objective basis for Claimant's complaints and rated Claimant able to do heavy work. (Tr. 184). Lalonde noted that Claimant had received therapy services from Affiliated on March 6, and in June, 2001. (Tr. 159, 160).

E. Testimony of Drs. Ted J. Hudspeth, E. Thomas Cullom, Robert L. Applebaum

Claimant's family physician, Dr. Hudspeth, testified that he began treating Claimant in May, 1997, for chest pain and hyperlipidemia, and thereafter, saw him for that condition on two other occasions in September and October, 1997. On March 13, 1998, Claimant was seen for low back pain with a history of low back, job related injuries. X-rays and a CAT scan were performed showing bulges at L4-5, L5-S1. (CX-20, pp. 8-10). Claimant was referred to Dr. Provenza who found lumbar disc herniation with extensor muscle weakness, but with a good response to conservative care and allowing Claimant to resume work as tolerated. *Id.* at 12-14.

Claimant next saw Dr. Hudspeth on March 6, 2001 during which Claimant reported an injury on February 23, 2001, while working for Employer when he slipped while marking welds. On exam, Claimant exhibited muscle spasm and tenderness of both latisimus dorsi and the right sacroiliac joint for which Dr. Hudspeth prescribed Skelaxin, Darvocet, and Celebrex and physical therapy. *Id.* at 18-22. On March 20, and April 23, 2001, Claimant made return visits exhibiting the same signs for which Dr. Hudspeth continued the medical and physical therapy regime and ordered an MRI. Dr. Hudspeth read the MRI as showing a herniated disc at L2-3, moderate bulging at L4-5, and moderate bulging at L5-S1 with minimal indentation of the thecal sac compatible with herniation. *Id.* at 28-28.

Dr. Hudspeth opined that the February 23, 2001 injury was either a new injury or an aggravation of an old injury, and due to the persistent back pain referred Claimant to Dr. Cullom. *Id.* at 35. Dr. Hudspeth further opined that heavy lifting would aggravate Claimant's symptoms, as would repetitive bending, stooping, and squatting. *Id.* at 36-38. Dr. Hudspeth had no explanation for Claimant's failure to complete the second day of FCE testing except to say that the tasks he was asked to do could have aggravated Claimant's symptoms, and further, that Claimant was an individual who when asked to give his best effort would do so. *Id.* at 40, 41.

Dr. Cullom testified that work compensation case manager, Ryan Downs, referred Claimant to him for neurological evaluation and not treatment with the initial visit on April 30, 2001. (CX-23, p. 7, 80). Claimant described the accident of February 23, 2001 and subsequent treatment at the shipyard, and by Dr. Hudspeth for low back and right leg pain. *Id.* a 8. Dr. Cullom read the MRI of April 24, 2001, which he incorrectly identified as September 24, 2001, as showing degenerative changes at L4-5 and L5-S1 with endplate changes and a Schmorl's node at L4-5, a slight bulge at L4-5 and some facet hypertrophy and a central protrusion at L5-S1. Dr. Cullom diagnosed degenerative disc disease with sacroiliac joint dysfunction. *Id.* at 9 and 10. (The MRI findings as reported by radiologist, Dr. Randall E. Sellers, showed abnormalities at L2-3 with indentation of the thecal sac and the appearance of extruded disc material, moderate annular bulging at L4-5 with indentation of the thecal sac and facet arthropathy and ligamentum flavum hypertrophy and moderate annular bulging and indentation of the thecal sac at L5-S1.) (CX-16, p.11).

Dr. Cullom then described Claimant's second and third visit on June 7, and July 26, 2001 where he voiced similar complaints and showed minimal response to conservative treatment which prompted Dr. Cullom to order an FCE. (CX-23, pp. 11,12). Upon receiving the FCE, Dr. Cullom concluded there was no objective basis for Claimant's pain complaints and thereafter sent in a work release with no restrictions. *Id.* at 13,14. Dr. Cullom testified that he did not agree with Dr. Sellers' assessment of herniation at L2-3 and did not regard the mild indentation of the thecal sac to be of any importance. *Id.* at 24- 29. Dr. Cullom admitted that a herniated disc could result in back pain, leg pain, weakness and numbness as well as disc degeneration which is caused by a combination of aging and trauma. *Id.* at 33-36. Further, a degenerative disc was more susceptibly to traumatic injury because of a weakened condition, than one that had not degenerated and that the type of back injuries that can result in pain included, falling and heavy lifting. *Id.* at 44.

Dr. Cullom further admitted that he had not received the March,1998, CAT scan, which was read as showing a diffuse annular bulge with mild central and left paracentral disc protrusion (herniation) at L4-5. *Id.* at 59-62. He also admitted that if a patient had a L4-5 disc herniation with symptoms such as back pain, leg pain, weakness and numbness he should avoid lifting over 15 pounds, no bending, or twisting. *Id.* at 66. However, Dr. Cullom testified that he did not find Claimant's injury to be compatible with severe pain, but rather, thought Claimant was lying about his symptoms with inconsistent results and no objective evidence produced from the FCE testing. *Id.* at 84, 85.

Dr. Applebaum testified that he saw Claimant one time on September 13, 2002**,** during which he interviewed and examined Claimant and reviewed his medical records. (CX-28, p. 6.). Claimant

described his injury and symptoms and past treatment which included Dr. Collum's evaluation and release to return to work followed by an additional evaluation by Dr. Jackson. *Id.* at7. Claimant complained of throbbing and constant low back pain which increased with sitting or standing and diminished with rest and occasional right sacroiliac joint and buttock pain. *Id.* t 8. The back examination showed minimal limitation of motion, slight flattening of the lumbosacral curse, positive straight leg raising at 10 degrees on the right and 40 degrees on the left with positive Lasegue and bowstring signs bilaterally. The Patrick's sign was weakly positive bilaterally with internal hip rotation. The right sacroiliac joint was tender. Dr. Applebaum noted a history of back and leg injury in February, 2001, resulting in moderate mechanical and no neurological deficits. Dr. Applebaum recommended a lumbar myelogram and CAT scan to rule out specific spinal problems, continue use of Celebrex and a bone scan. *Id.* at 9-11.

Dr. Applebaum reviewed the April 24, 2001 MRI and found evidence of degenerative disc disease at L4-5 with a slight bulge, a slight bulge at L2-3 of no clinical significance and no evidence of herniation or nerve root compression. Dr. Applebaum found Claimant could do light work but was not certain Claimant had reached MMI because further evaluation was necessary. *Id.* at 12, 13. Specifically, Dr. Applebaum limited Claimant to no prolonged bending, stooping, and lifting more than 20 to 30 pounds finding a consistency between Claimant's symptoms and his exam. *Id.* at 15.

Under cross, Dr. Applebaum went over Claimant's medical history noting lumbar strains in November, 1990, followed by additional back injuries in March, 1991; July, 1992; September, 1994; March,1998; and February, 1999 and February, 2001. Dr. Applebaum found Claimant's pain complaints to be consistent with his injuries limiting him to no stooping, squatting, or kneeling, and lifting 20 to 30 pounds, alternate sit/stand every half hour and recommended again a lumbar myleogram and CAT scan so as to get a better bony image. *Id.* at 50-55.

IV. DISCUSSION

A. Contention of the Parties:

Employer contends that Claimant is not disabled and should have returned to work at its facility doing his former heavy duty welding assignments when directed by Downs to do so in September, 2001. Because Claimant failed to resume work he was able to do so, Employer is relieved of any further compensation or medical payments obligation. Employer asserts that Dr. Collum was Claimant's choice of physician and that when he found Claimant able to return to work without restriction, which was supported by the FCE, Employer rebutted any Section 20(a) presumption.[4] Dr. Collum's finding of no neurological impairments was supported by both Dr. Jackson, and Dr.

[4]Claimant agrees that Dr. Hudspeth referred Claimant to Dr. Cullom but that he is nonetheless entitled to a choice of a different physician pursuant to Section 907 (b) in that he regards Claimant as a liar when relating pain complaints and put him back to doing heavy work despite the fact that he has two herniated discs.

Applebaum who found Claimant able to return to work. Further, Employer showed the existence of suitable alternative employment by Claimant's admission that he had obtained and kept two jobs, maintenance mechanic for Winn Dixie and welder for Bristers Design and Manufacturing.

Claimant contends on the other hand that he suffered a significant back injury on February 23, 2001 which raised his constant level of pain to a 5 out 10. Pain levels increased to a level 8 out of10 when he performed heavy work on the first day of the FCE. Claimant reasonably anticipated experiencing severe pain level if he returned to his former welding job which involved heavy lifting, pushing and pulling. Thus, he acted reasonably when he told Ms. Landry that he could not perform welding duties when he reported on September 26, 2001.

Claimant argues that as a result of the February 23, 2001 fall he herniated two disc at L2-3 and L5-S1 involving nerve root impingement. Dr. Hudspeth diagnosed the herniation and nerve root impingement. A November 6, 2002 myleogram and post-myleogram CT moreover confirmed the herniation. Alternatively, the fall aggravated an old injury resulting in an inability to perform his past work due to severe pain levels. In any event, Claimant is and has been unable to perform his past welding job since the February 23, 2001 injury and is entitled to temporary total disability during any subsequent period of unemployment and temporary partial disability during his periods of employment with Winn Dixie and Bristers Design.

Although Employer never addressed the issue of MMI in its brief, it would appear Employer is relying upon Dr. Cullom who picked August 13, 2001 when Claimant completed the first day of his FCE. Claimant on the other hand apparently relies upon Dr. Applebaum who found Claimant was not at MMI but rather needed additional testing.

B. Claimant's Credibility, Section 20 (a) Presumption and Causation

It is well-settled that in arriving at a decision in this matter the finder of fact is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467 (1968); *Atlantic Marine, Inc. v. Bruce*, 661 F.2d 898, 900 (5th Cir. 1981); *Todd Shipyards Corporation v. Donovan*, 300 F.2d 741, 742 (5th Cir. 1962). A claimant's discredited and contradicted testimony is insufficient to support an award. *Director, OWCP v. Bethlehem Steel Corp.*, 620 F.2d 60, 64-65 (5th Cir. 1980); *Mackey v. Marine Terminals Corp.*, 21 BRBS 129, 131 (1988); *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981).

An employee is aided by the Section 20 presumption that the claim comes within the provisions of the Act unless there is substantial evidence to the contrary. 33 U.S.C. § 920 (2000). All factual doubts must be resolved in favor of the claimant. *Morehead Marine Services, Inc. v. Washnock*, 135 F.3d 366, 371 (6th Cir. 1998) (quoting *Brown v. ITT/Continental Baking Co.*, 921 F.2d 289, 295 (D.C. Cir. 1990)); *Wright v. Connolly-Pacific Co.*, 25 BRBS 161, 168 (1991). Under the Administrative Procedures Act, however, a claimant has the ultimate burden of persuasion by a preponderance of the evidence. *Director, OWCP v. Greenwich Colleries*, 512 U.S. 267, 281 (1994).

The Section 20(a) presumptions were left untouched by *Greenwich Colleries*. *Id* at 280. Thus, the Section 20(a) presumption applies in determining whether working conditions caused a claimant's injuries. *Kubin v. Pro-Football, Inc.*, 29 BRBS 117, 118 (1995).

Before invoking the Section 20(a) presumption, a claimant must first establish a *prima facie* case by showing that he suffered some harm and that working conditions existed which could have caused the harm. *O'Kelly v. Dep't of the Army*, 34 BRBS 39, 40 (2000). Once this is done he burden shifts to the Employer to show by substantial evidence, facts - not mere speculation - that the harm was not work-related." *Conoco, Inc., v. Director*, 194 F.23d 684 at 687-88 (5th Cir. 1999) (citing, *Bridier v. Alabama Dry Dock & Shipbuilding Corp.*, 29 BRBS 84 (1995)); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990); *Smith v. Sealand Terminal*, 14 BRBS 844 (1982).

In the present case, Claimant credibly testified about a February 23, 2001 back injury involving a slip and fall while at work marking welds on the Polar C hull as well as a series of prior back injuries while working for Employer in 1990, 1991, 1992, 1994, 1998, and 1999. Claimant recovered from the first four injuries without incident following conservative treatment. On the fifth injury in March,1998, Claimant was not as fortunate and experienced severe back pain preventing him from full duty work and requiring intervention by neurosurgeon, Dr. Provenza, who order a CT scan showing left paracentral disc protrusion (herniation) at L4-5 requiring use of Motrin, Soma and physical therapy. In February,1999, Claimant again experience severe low back pain while pulling welding leads resulting in additional therapy, limited duty, and a constant level 4 out of 10 back pain.

Unlike the previous injuries, the February 23, 2001 injury did not respond to conservative treatment from company physicians, Claimant's family physician, Dr. Hudspeth or neurosurgeon, Dr. Cullom, which included increased use of medication, physical therapy, and injections. Claimant credibly testified about experiencing a constant level 4 to 5 out of 10 back pain which increased to a level 8 or 9 with heavy lifting or prolonged sitting. Claimant credibly testified that following the first day of FCE testing on August 13, 2001, he was barely able to walk and was unable to complete the second day of testing. Claimant's testimony was supported by credible testimony from his wife, Sharon Miller.

Employer offered no credible testimony to rebut the fact that Claimant injured his back while at work on February 23, 2001. Rather, they offered testimony from Dr. Cullom and occupational therapist Kevin Lalonde to show that Claimant had completely recovered by August 13, 2001 when he reached MMI and was able to return to heavy duty work. This testimony is discussed below dealing with nature and extent of injury. Thus, I find the section 20 (a) presumption applies.

C. Nature and Extent of Injury and Date of Maximum Medical Improvement

Claimant seeks temporary total disability benefits from February 23, 2001 up to his subsequent employment with Winn Dixie from November 20, 2001 to June 28, 2002 when Claimant was forced to resign due to a falsification of his job application. During the period of employment with Winn Dixie Claimant seeks temporary partial disability followed by temporary total disability from June 28, 2002 to October 18, 2002 when unemployed followed by temporary partial disability while working for Bristers Design from October 19, 2002 to the present and continuing.

Disability under the Act is defined as "incapacity because of injury to earn wages which the employee was receiving at the time of injury in the same or any other employment." 33 U.S.C. § 902(10). Disability is an economic concept based upon a medical foundation distinguished by either the nature (permanent or temporary) or the extent (total or partial). A permanent disability is one which has continued for a lengthy period and is of lasting or indefinite duration, as distinguished from one in which recovery merely awaits a normal healing period. *Watson v. Gulf Stevedore Corp.*, 400 F.2d 649 (5th Cir. 1968); *Seidel v. General Dynamics Corp.*, 22 BRBS 403, 407 (1989); *Stevens v. Lockheed Shipbuilding Co.*, 22 BRBS 155, 157 (1989). The traditional approach for determining whether an injury is permanent or temporary is to ascertain the date of maximum medical improvement (MMI).

The determination of when MMI is reached, so that a claimant's disability may be said to be permanent, is primarily a question of fact based on medical evidence. *Hite v. Dresser Guiberson Pumping*, 22 BRBS 87, 91 (1989). *Care v. Washington Metro Area Transit Authority*, 21 BRBS 248 (1988). An employee is considered permanently disabled if he has any residual disability after reaching MMI. *Lozada v. General Dynamics Corp.*, 903 F.2d 168, 23 BRBS (CRT)(2d Cir. 1990); *Sinclair v. United Food & Commercial Workers* , 13 BRBS 148 (1989); *Trask v. Lockheed Shipbuilding & Construction Co.*, 17 BRBS 56 (1985). A condition is permanent if a claimant is no longer undergoing treatment with a view towards improving his condition, *Leech v. Service Engineering Co.*, 15 BRBS 18 (1982), or if his condition has stabilized. *Lusby v. Washington Metropolitan Area Transit Authority*, 13 BRBS 446 (1981).

In this case, I am persuaded by Dr. Applebaum's testimony that Claimant is not at MMI, but rather, needs additional testing to determine more precisely Claimant's back impairment and appropriate medical treatment. Dr. Applebaum after examining Claimant and the medical records available, found evidence of degenerative lumbar disc disease with moderate mechanical restrictions and restricted Claimant to light work involving lifting no more than 20 to 30 pounds with no stooping, squatting, or kneeling and with alternate sitting/standing every 30 minutes. Dr. Applebaum found Claimant's pain complaints to be consistent with his medical condition and history of prior back injuries which he classified as lumbar strains. Dr. Jackson also found Claimant's pain complaints to be valid considering his spinal condition and found him unable to work.

I do not credit Dr. Cullom's assessment of MMI as of August 13,2001, because it appears to be based on nothing more than one day of FCE testing and no further examinations of Claimant from which Dr. Cullom concluded that Claimant was a liar and could do heavy work. Indeed, from Dr. Cullom's records it appears that Claimant suffered from degenerative disc disease with sacroiliac joint dysfunction, and would, thus have some work restrictions. However, Dr. Cullom without even talking to Claimant merely accepted Lalonde's one day FCE testing and concluded that he did not suffer from disc herniation without benefit of the March, 1998, CT scan, which was read as showing herniation at L4-5 or the November 6, 2002 lumbar myelogram and post-myleogram CT showing degenerative changes at L4-5 with significant stenosis due to extruded or protruded type disc herniation. Dr. Cullom admitted, however, that disc herniation or degeneration could produce back and leg pain with weakness and numbness as a result of either heavy lifting or falling, and thus, restrict Claimant to lifting no more than15 pounds with no bending or twisting.

D. Prima Facie Case of Total Disability and Suitable Alternative Employment

The Act does not provide standards to distinguish between classifications or degrees of disability. Case law has established that in order to establish a *prima facie* case of total disability under the Act, a claimant must establish that he can no longer perform his former longshore job due to his job-related injury. *New Orleans (Gulfwide) Stevedores v. Turner*, 661 F.2d 1031, 1038 (5th Cir. 1981); *P&M Crane Co. v. Hayes*, 930 F.2d 424, 429-30 (5th Cir. 1991); *SGS Control Serv. v. Director, Office of Worker's Comp. Programs*, 86 F.3d 438, 444 (5th Cir. 1996). He need not establish that he cannot return to *any* employment, only that he cannot return to his former employment. *Elliot v. C&P Telephone Co.*, 16 BRBS 89 (1984). The same standard applies whether the claim is for temporary or permanent total disability. If a claimant meets this burden, he is presumed to be totally disabled. *Walker v. Sun Shipbuilding & Dry Dock Co.*, 19 BRBS 171 (1986).

Once the *prima facie* case of total disability is established, the burden shifts to the employer to establish the availability of suitable alternative employment. *Turner*, 661 F.2d at 1038; *P&M Crane*, 930 F.2d at 430; *Clophus v. Amoco Prod. Co.*, 21 BRBS 261, 265 (188). Total disability becomes partial on the earliest date on which the employer establishes suitable alternative employment. *SGS Control Serv. v. Director, OWCP*, 86 F.3d 438, 444 (5th Cir. 1996); *Palombo v. Director, OWCP*, 937 F.2d 70, 73 (D.C. Cir. 1991); *Rinaldi v. General Dynamics Corp.*, 25 BRBS 128, 131 (1991). A finding of disability may be established based on a claimant's credible subjective testimony. *Director, OWCP v. Vessel Repair, Inc.*, 168 F.3d 190, 194 (5th Cir. 1999) (crediting employee's reports of pain); *Mijangos v. Avondale Shipyards, Inc.*, 948 F.2d 941, 944-45 (5th Cir. 1991)(crediting employee's statement that he would have constant pain in performing another job). An Employer may establish suitable alternative employment retroactively to the day Claimant reached maximum medical improvement. *New Port News Shipbuilding & Dry Dock Co.*, 841 F.2d 540 (4th Cir. 1988); *Bryant v. Carolina Shipping Co., Inc.*, 25 BRBS 294 (1992). Where a claimant seeks benefits for total disability and suitable alternative employment has been established, the earnings established constitute the claimant's wage earning capacity. *See Berkstresser v. Washington Metro. Area Transit Auth.*, 16 BRBS 231, 233 (1984).

The Fifth Circuit has articulated the burden of the employer to show suitable alternative employment as follows:

> Job availability should incorporate the answer to two questions. (1) Considering claimant's age, background, etc.., what can the claimant physically and mentally do following his injury, that is, what types of jobs is he capable of performing or capable of being trained to do? (2) Within this category of jobs that the claimant is reasonably capable of performing, are there jobs reasonably available in the community for which the claimant is able to compete and which he could realistically and likely secure? . . . This brings into play a complementary burden that the claimant must bear, that of establishing reasonable diligence in attempting to secure some type of alternative employment within the compass of employment opportunities shown by the employer to be reasonably attainable and available.

Turner, 661 F.2d at 1042-43 (footnotes omitted).

In this case, I am convinced based upon Claimant's credible testimony and that of Dr. Applebaum's and Dr. Jackson's examinations, together with the CAT scans and MRI that as a result of the February 23, 2001 injury, that Claimant cannot perform his past heavy work for Employer and thus, has been temporarily and totally disabled from February 23, 2001 up through November 19, 2001. Thereafter, from November 20, 2001 to present, Claimant has been temporarily and partially disabled based upon his successful employment with Winn Dixie and Bristers. I do not find it appropriate to put Claimant back on total disability after resigning from Winn Dixie because he lost that job due to a falsification of job application and not due to an inability to perform such because of physical impairments.

Claimant worked successfully at Winn Dixie for a substantial period of time (November 20, 2001 through June 28, 2002) starting out at $12.00 per hour. Claimant had a good attendance record (late 1 time, left work early 1 time, and absent 1 time). His overall work evaluation was good with payroll records showing full time employment. (EX-14). As a maintenance man Claimant was responsible for maintaining a Blow-Mode machine that made plastic milk bottles. Claimant did no heavy lifting or pulling and could schedule breaks as needed to relieve non severe (level 4 to5) back pain. While Claimant asserted that he missed 4 to 5 days of work because of his back problems, payroll records do not support an assertion. Moreover, there is no proof that the Winn Dixie job required him to seek additional medical help or increase medications or required him to lie down when coming home as was the case with the FCE. (Tr. 88-91). As such, I consider the Winn Dixie job to constitute suitable alternative employment and not one where he was required to work in severe pain.

Even assuming, *arguendo*, that Claimant has only lumbar disc degeneration and not a combination of both degeneration and herniation which I find to be more probable in light of the recent CT scan and myleogram, I am convinced that Claimant's pain complaints are genuine and resulted from

the February 23, 2001 injury and prevented him from continuing to work as a welder for Employer but did not prevent him from finding suitable alternative employment with Winn Dixie. An aggravation or progression of Claimant's underlying disease is not necessary for the injury to be compensable, an increase in symptoms resulting in disability is sufficient. *Crum v. General Adjustment Bureau,* 738 f. 2d.474 (D.C. Cir. 1984), *Gardner v. Director, OWCP,* 640F.2d 1385 (1st.Cir, 1981) *aff'g Gardner v. Bath Iron Works Corp,* 11 BRBS 556 (1979).

E. Choice of Physician

Claimant contends that he is entitled to a choice of physicians other than Dr. Cullom. Claimant's entitlement to choose his own physician is set forth in Section 7 of the Act.

> The employee shall have the right to choose an attending physician authorized by the Secretary to provide medical care under this chapter as hereinafter provided. . . . The Secretary shall . . . have authority to determine the necessity, character, and sufficiency of any medical aid furnished or to be furnished, and may . . . order a change of physicians . . . when in his judgment such change is desirable or necessary in the interest of the employee or where the charges exceed those prevailing within the community for the same or similar services or exceed the provider's customary charges. Change of physicians at the request of employees shall be permitted in accordance with regulations of the Secretary.
>
> . . . . Whenever the employer or carrier acquires knowledge of the employee's injury . . . the employer or carrier shall forthwith authorize medical treatment and care from a physician selected by an employee. . . . An employee may not change physicians after his initial choice unless the employer, carrier, or deputy commissioner has given prior consent for such change. Such consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for and appropriate to the proper care and treatment of the compensable injury or disease. In all other cases, consent may be given upon a showing of good cause for change.

33 U.S.C. § 907(b-c) (2001). *See also* 20 C.F.R. § 702.403 (2001)(stating that the "employee shall have the right to choose his/her treating physician among those authorized by the Director . . .").

In general, an employer whose worker is injured on the job is, pursuant to Section 7(a) of the Act, responsible for those medical expenses reasonably and necessarily incurred as a result of a work-related injury. *Ingalls Shipbuilding Inc. v. Director, OWCP*, 991 F.2d 163 (5th Cir. 1993); *Perez v. Sea-Land Services, Inc.*, 8 BRBS 130 (1978). An employee has a right to choose an attending physician authorized by the Secretary to provide medical care. 33 U.S.C. § 907(b) (2002). When a claimant wishes to change treating physicians, the claimant must first request consent for a change and

consent shall be given in cases where an employee's initial choice was not of a specialist whose services are necessary for, and appropriate to, the proper care and treatment of the compensable injury or disease. 33 U.S.C. § 907(c)(2) (2002); 20 C.F.R. § 702.406(a) (2001); *Armfield v. Shell Offshore, Inc.*, 25 BRBS 303 (1992) (Smith, J., dissenting on other grounds); *Senegal v. Strachan Shipping Co.*, 21 BRBS 8 (1988). Otherwise, an employee may not change physicians after his initial choice unless the employer, carrier, or deputy commissioner has given prior consent. 33 U.S.C. 907(c)(2) (2001). "In all other case, consent may be given upon a showing of good cause for change." *Id*.

The pain language of Section 7(c)(2) states that the employer may consent to a change of physician for good cause but is not required to. *Swain v. Bath Iron Works Corp.*, 14 BRBS 657, 665 (1982) (stating that even if the clamant had established "good cause" for change the employer was not required to authorize the change). Jurisprudence has established several instances where the claimant failed to even demonstrate "good cause" for change. *See Lyles v. Stevedoring Services of America*, 34 BRBS 303, 305-06 (2000) (ALJ) (denying the claimant a right to change physicians for "good cause" when the claimant was already being treated by a specialist and only sought to change specialists after being released to return to work); *Mull v. Newport News Shipbuilding & Dry Dock Co.*, 29 BRBS 739, 741-43 (1995) (ALJ) (determining that there was not "good cause" to change physicians when the claimant consciously chose a treating physician, that physician treated her for seven months, she chose another specialist in the same field without gaining approval from the employer, and when she only sought to change physicians after the first physician opined that her injuries were not work related). *Cf. Baily v. Palmetto Shipbuilding & Stevedoring Co.*, 27 BRBS 370 (1993) (ALJ) (finding that the death of the claimant's prior treating physician constituted "good cause" to change treating physicians); *Gaudet v. New Orleans Shipyard*, 24 BRBS 31 (1990) (ALJ) (finding the employer was required to consent to a change in physicians for "good cause," and labeling the change as a "referral" when the claimant sought a change of orthopaedist for a specific purpose, namely that the second orthopaedist was a "leading spine surgeon" who was more capable of performing the particular operation).

When a treating physician selected by the employer declares that the employee is recovered and discharged from treatment, that may be tantamount to the employer's refusing to provide treatment. *Shahady v. Atlas Tile & Marble Co.*, 682 F.2d 968 (D.C. Cir. 1982)(finding a refusal to provide medical treatment on behalf of the employer when the employer's physician told the claimant that he had recovered from his injury and required no further treatment); *Atlantic Gulf Stevedores, Inc. v. Newman*, 440 F.2d 908 (5th Cir. 1971) (same); *Gros v. Fred Settoon, Inc.*, 35 BRBS 343 (2001) (ALJ). Subsequently, the employee need only establish that further medical treatment was reasonable and necessary to obtain reimbursement form the employer. 33 U.S.C. § 907(d) (2002); *Rogers Terminal & Shipping Corp. v. Director, OWCP*, 784 F.2d 687, 692-93 (5th Cir. 1986). Conversely, when a claimant's treating physician refuses to provide further medical treatment, that does not relieve the claimant of the obligation to request another choice of physician of his employer under Section 7(b). *Slattery Associates, Inc. v. Hartford Accident & Indemnity Co.*, 725 F.2d 780, 786 (D.C. Cir. 1983).

In this case, it is clear that Claimant chose Dr. Hudspeth as his treating physician. Thereafter, Dr. Hudspeth decided to refer Claimant for specialized care to Dr. Cullom. However, Dr. Cullom considered the referral as coming not from Dr. Hudspeth, but rather, Carrier's adjuster, Ryan Downs and thereafter treated him on 3 occasions acting under that assumption. (EX-7, p. 7, EX-23, p. 7). Under those circumstances, Dr. Cullom cannot be considered to be Claimant's choice, but rather, Employer's choice. When Dr. Cullom subsequently informed Employer/Carrier that he had nothing further to offer Claimant and refused to schedule another appointment with Claimant, such conduct constituted a refusal to provide medical treatment allowing Claimant to seek treatment elsewhere without Employer's authorization provided such treatment was reasonable and necessary. *Matthews v. Jeffboat, Inc.*, 18 BRBS 185 (1986); *Rivera v. National Metal & Steel Corp.*, 16BRBS 135 (1984).

Claimant demonstrated the need for additional neurosurgical evaluation and treatment by the subsequent examinations of Drs. Jackson and Applebaum. Accordingly, I find that Claimant has the right to choose his own neurosurgeon and is thus, not required to stay with Dr Cullom. Alternatively, since treatment reverted back to Dr. Hudspeth once Dr. Cullom refused to provide additional services, it may be said that there has been no change in treating physicians since Dr. Hudspeth was Claimant's original choice and thus, Dr. Hudspeth may refer Claimant to another neurosurgeon for follow up care. In any event, Employer may not rely upon Dr. Cullom's refusal to deny Claimant the right to seek and secure appropriate medical care from a neurosurgeon of his own choosing.

F. Interest and Attorney Fees

Although not specifically authorized in the Act, it has been an accepted practice that interest at the rate of six per cent per annum is assessed on all past due compensation payments. *Avallone v. Todd Shipyards Corp.*, 10 BRBS 724 (1974). The Benefits Review Board and the Federal Courts have previously upheld interest awards on past due benefits to insure that the employee receives the full amount of compensation due. *Watkins v. Newport News Shipbuilding & Dry Dock Co., aff'd in pertinent part and rev'd on other grounds, sub nom. Newport News v. Director, OWCP*, 594 F.2d 986 (4th Cir. 1979). The Board concluded that inflationary trends in our economy have rendered a fixed six per cent rate no longer appropriate to further the purpose of making Claimant whole, and held that "the fixed per cent rate should be replaced by the rate employed by the United States District Courts under 28 U.S.C. § 1961 (2002)." This order incorporates by reference this statute and provides for its specific administrative application by the District Director. *See Grant v. Portland Stevedoring Company, et. al.*, 17 BRBS 20(1985). The appropriate rate shall be determined as of the filing date of this Decision and Order with the District Director.

G. Attorney Fees

No award of attorney's fees for services to the Claimant is made herein since no application for fees has been made by the Claimant's counsel. Counsel is hereby allowed thirty (30) days from the date of service of this decision to submit an application for attorney's fees. A service sheet showing that service has been made on all parties, including the Claimant, must accompany the petition. Parties have

twenty (20) days following the receipt of such application within which to file any objections thereto. The Act prohibits the charging of a fee in the absence of an approved application.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

1. Employer shall pay to Claimant temporary total disability compensation pursuant to Section 908(b) of the Act for the period from February 23, 2001 through November 19, 2001, based on an average weekly wage of $635.83 and a corresponding compensation rate of $423.89.

2. Employer shall pay to Claimant temporary partial disability compensation pursuant to Section 908(e) of the Act for the period from November 20, 2001 to present and continuing based on an average weekly wage of $635.83, and a post-injury wage earning capacity of $462.17 ($480.00 minus interim inflation increase of 3.61% of $17.83) and a corresponding compensation rate of $115.77.

3. Employer shall be entitled to a credit for all compensation paid to Claimant from February 26, 2001 through September 9, 2001 totaling $11,969.20.

4. Claimant is entitled to a choice of neurosurgeons pursuant to Section 7 of the Act as well as all future reasonable and necessary medical care arising out of his work related injury of February 23, 2001.

5. Employer shall pay Claimant interest on accrued unpaid compensation benefits. The applicable rate of interest shall be calculated in accordance with 28 U.S.C. §1961.

6. Claimant's counsel shall have thirty (30) days to file a fully supported fee application with the Office of Administrative Law Judges, serving a copy thereof on Claimant and opposing counsel who shall have twenty (20) days to file any objection thereto.

A

CLEMENT J. KENNINGTON
ADMINISTRATIVE LAW JUDGE